STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	R-C 12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the investigation of Complaints IN00099184 and IN00099274 completed on 11/10/11. This visit was in conjunction with the investigation of Complaint IN00100023. Complaint IN00099184-Corrected. Complaint IN00099274-Corrected Survey dates: December 13,14,15, 2011 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Survey team: Ann Armey, RN Census bed type: SNF/NF: 134 Total: 134 Census payor type: Medicare: 15 Medicaid: 94 Other: 25 Total: 134 Sample: 7 Kindred Transitional Care was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the investigation of Complaints IN00099184 and IN00099274.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	R-C 12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Quality review completed 12/16/11 Cathy Emswiller RN	{F 000}		